Electronic Claim Adjustments

User Guide

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251405-16

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Contents

Introduction

BCBSAZ accepts the HIPAA 837 transaction sets* for electronic professional (837P), institutional (837I) and dental (837D) claim adjustments.

The material in this user guide includes information on processes and HIPAA data requirements necessary for electronically submitted claim adjustments.

Note: The BCBSAZ HIPAA Companion Guide also includes electronic claim adjustment information unique to BCBSAZ. Providers can access the Companion Guide on azblue.com/providers under "Electronic Business."

*HIPAA 837 transactions sets are used to electronically submit health care claim billing information or encounter information from healthcare providers to health plans or payers either directly or via intermediary billers or claims clearinghouses.

Request for reconsideration or adjustment of adjudicated claims

The 837 electronic claim adjustment requests follow the same guidelines stated in the BCBSAZ Provider Operating Guide under Request for Reconsideration or Adjustment of Adjudicated Claims (Section 16).

Appeals and grievance procedures

BCBSAZ will not accept appeals and grievances via an 837 adjustment request. Please refer to the Provider Operating Guide (Section 21) for additional information. BCBSAZ will **RETURN** these types of 837 adjustment requests when received electronically.

837 Electronic claim adjustment reasons

All adjustments may be submitted electronically. Changes to the items listed below are allowed in adjustments which may be submitted electronically to BCBSAZ. This is not an all-inclusive list:

- Patient name
- Place of service
- Date of service
- Billed charges
- Adding and/or changing modifiers
- Member ID
- Number of units
- Changing the sequence of diagnosis codes
- Late charges to inpatient or outpatient claims
- Other billing
- Provider number
- Anesthesia time
- Other insurance carrier COB payment

What must be submitted on paper with documentation

The current process to submit Appeals and Grievances requires that documentation be submitted with the request. Continue to submit on paper with the appropriate documentation. Please refer to the Provider Operating Guide (Sections 21/22) for appeal and grievance procedures. BCBSAZ will **RETURN** these types of 837 adjustment requests when received electronically.

Frequently Asked Questions (FAQ) to help you set up your systems

The following FAQs are to assist you with understanding the electronic 837 adjustment request process and data element requirements.

Q1. *Who can submit electronic 837 adjustments?*
A1. All providers who currently send electronic 837 claims can submit 837 adjustment requests.

Q2. *What kind of adjustments can I send?*
A2. Providers can submit any adjustments as outlined below. Lines of Business (LOBs) and Claim Types (Type of Bill) included are:

Included:

- Local Professional, Institutional & Dental
- FEP Professional, Institutional & Dental
- BlueCard Host Professional & Institutional
- CHS Professional, Institutional & Dental

Excluded:

- BlueCard Host Dental

Q3. *How are the adjustments sent / submitted?*
A3. The provider follows the same process they currently follow to submit electronic claims.

Q4. *If I have questions about the submission of electronic claims, who should I contact?*
A4. For information on electronic claim solutions, contact BCBSAZ eSolutions at (602) 864-4844, (800) 650-5656 or email eSolutions@azblue.com.

Q5. *How do I indicate the electronic claim is an adjustment?*
A5. The provider will indicate the following:

For Institutional Claims
The 3rd position of the Type of Bill (Values 7 or 8) indicates the claim is an adjustment.

For Professional and Dental Claims
The Frequency Code (Values 7 or 8) associated with the Place of Service on Professional and Dental claims. This indicates the claim is an adjustment.

Note: Please refer to your specific claim type located in the 837 Data Elements for Adjustments section on pg.7 - 9.

Q6. *How do I communicate what I want to have adjusted?*
A6. BCBSAZ will require the following information be submitted within the electronic 837 adjustment request.

- Frequency Code
  - Must be present. Indicates the claim is an adjustment and can only be frequency codes 7 or 8
- Original Reference Number
  - Must be present. Claim number reported on the remittance advice you received concerning the previous adjudication.

Q7. *Are eadjustment Conditions Codes required?*
A7. *No. But If submitted please refer to the following list for the values that BCBSAZ will accept:*

D0	*Changes to Service Date (Statement Dates)*
D1	*Changes to Charges*
D2	*Changes in Revenue Codes/HCPCS/HIPPS Rate Codes*
D3	*Second or Subsequent Interim PPS Bill*
D4	*Change in clinical Codes (ICD) for Diagnosis and/or Procedure Codes*
D7	*Changes to Make Medicare the Secondary Payer*
D8	*Changes to Make Medicare the Primary Payer*
D9	*Any other Change (including changes to service level dates)*
E0	*Change in Patient Status*

Q8. *What elements will be affected in my billing system and what do I tell my vendor regarding any required changes?*
A8. The portion of the BCBSAZ Companion Guide for elements required on an 837 adjustment request (Professional, Dental and Institutional) can be found on pages 4 – 5. Please use these requirements when working with your vendor when making the necessary changes to your billing systems.

Q9. *How will I know the adjustment was received by BCBSAZ?*
A9. The current Arizona Blue Direct Connect (ABDC) Reporting will include adjustment receipts.

Q10. *Can I submit my daily electronic claims with my electronic adjustment requests in the same file?*
A10. Yes.

Q11. *Are Medicare Cross-over electronic 837 adjustments included in this process?*
A11. Yes. The Medicare contractor will send adjustment 837s to BCBSAZ for Local, and Senior Product Lines of Business (exclude FEP).

Q12. *How should I submit Medicare cross-over adjustments?*
A12. Adjustments where Medicare is primary **MUST** be sent directly to Medicare. The adjustment, once processed by Medicare, will be electronically crossed over to BCBSAZ (excludes FEP).

Q13. *Can I continue to submit adjustment requests on paper?*
A13. Yes. Corrected claim adjustments may be submitted on paper, however, if submitted electronically (as an 837) may be handled more quickly and reduce paper handling.

Required loops and data elements

Certain conditions must be met in order for BCBSAZ to accept 837 adjustment requests. The tables provided below define, by Professional, Institutional and Dental, the **required** data elements that must be submitted within each 837 adjustment request. The required data elements are needed to assist BCBSAZ to determine the how the adjustment request will be processed. If the information is not provided, the adjustment request will be electronically returned to the submitter/provider.
Note: Frequency codes other than 7 or 8 will not be accepted electronically.

837 PROFESSIONAL – Data elements for adjustments

ASC_X12N/005010X222_A1/E1 ASC X12 Standards for Electronic Data Interchange Technical Report Type 3						
TR3Page #	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
159	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	7 8	1/1	**Required:** Must = **7(**Replacement of prior claim) or **8** (Void/Cancel of prior claim)
196		REF01 - Claim Information	Reference Identifier Qualifier	F8	2/3	**Required:** Insert "F8"
196		REF02 - Claim Information	Reference Identification	AN	1/30	**Required:** For **Local & FEP**, ICN/DCN must be 15 numeric characters. For **BlueCard**, ICN/DCN must be 15-17 numeric characters

837 DENTAL – Data elements for adjustments

ASC_X12N/005010X222_A1/E1 ASC X12 Standards for Electronic Data Interchange Technical Report Type 3						
TR3Page#	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
147	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	7 8	1/1	**Required: Must = 7** (Replacement of prior claim) or **8** (Void/Cancel of prior claim)
168		REF01 – Claim Information	Reference Identifier Qualifier	F8	2/3	**Required:** Insert "F8"
168		REF02 – Claim Information	Reference Identification	AN	1/30	**Required:** For **Local & FEP**, ICN/DCN must be 15 numeric characters.

837 INSTITUTIONAL – Data elements for adjustments

ASC_X12N/005010X222_A1/E1 ASC X12 Standards for Electronic Data Interchange Technical Report Type 3						
TR3Page #	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
145	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	7 8	1/1	**Required: Must = 7**(Replacement of prior claim) or **8** (Void/Cancel of prior claim)
166		REF01 – Claim Information	Reference Identifier Qualifier	F8	2/3	**Required:** Insert "F8" (Orig Ref #)
166		REF02 – Claim Information	Reference Identification	AN	1/30	**Required:** For **Local & FEP**, insert ICN/DCN must be 15 numeric characters. For **BlueCard**, ICN/DCN must be 15-17 numeric characters.